Analytic Group Psychotherapy

For Wives and Husbands

I. W. RUSKIN, M.D., *Los Angeles*

• *The practice of group psychotherapy has its roots in Freudian dynamics and concepts, and varies from play group psychotherapy to analytic group psychotherapy, using the dynamics of transference, catharsis, interpretation, insight, ego building, reality, and sublimation.*

This presentation is based on the experience of the author with about 40 women patients formed in groups at a sanatorium. The majority were neurotic, psychoneurotic or manic-depressive. Several were psychotic. Some of the patients were treated in groups that included their husbands, after discharge from the sanatorium.

Analytic group psychotherapy is a concept of an attenuated mobile and uncensored societal setting, where persons who have failed in the larger and harsher social reality may again attempt resocialization in a permissive, friendly, and protected environment. It is not to be considered the poor man's makeshift for individual psychoanalysis. Group dynamics facilitate the regression and catharsis necessary to produce insight and ego strength, leading to more rapid recovery.

Husband and wife participation in the same group led to a more tolerant acceptance by the husband of the concept of mental ailment, and empathy for the spouse.

The role of the psychiatrist in group psychotherapy is very similar to that in individual psychoanalysis. He represents the reality to the patient and the group. He is objective but permissive, and not passive. Therapeutic goals are the same as in individual therapy, and may focus on the resolution of pre-oedipal conflicts or on situational maladjustments.

GROUP PSYCHOTHERAPY was first advocated in America. Although two students and associates of the French psychiatrist, Dejerene, in a book published in 1904 remarked upon the relative improvement of psychoneurotic patients treated in groups in a large ward as compared with the more opulent patients treated in private rooms, they did not call attention to the significant point, that the patients in wards exercised a reciprocal influence on each other. In 1905, Dr. Joseph H. Pratt, an internist and now professor emeritus of medicine, Tufts College Medical School, initiated a system of friendly counselling and inspirational lectures to groups of patients with pulmonary tuberculosis. He called these sessions "thought control" and, later, "classes in applied psychology." From 1906 to 1934, he published eight articles on group psychotherapy.

Many others followed or began that kind of therapy independently. Some of these are J. L. Moreno, whose particular contribution was psychodrama, at first with children in Vienna, later at St. Elizabeth's Hospital, Washington, D. C., and Dr. Edward Lazell who in 1920 started group psychotherapy at the same hospital by means of lectures to patients. Under the influence of Dr. W. A. White, a large scale project was started at St. Elizabeth's with remarkable results. L. C. Marsh at Kings Park State Hospital, New York, in reporting the good results of group psychotherapy, stated that "institutions for mental patients should be considered schools rather than hospitals—and the mental patient should be regarded not as a patient but as a student who has received a 'condition' in the great subject of civilization, as most of us understand it, and psychiatry should thus approach him with an intent to reeducate rather than with an intent to treat."

Drs. Louis Wender and Paul Schilder, searching independently for some means to reach the greatest numbers of patients in state mental hospitals, published their findings in 1936. A. A. Low and J. W. Klapman in Chicago and Fritz Redl in Detroit pioneered in group psychotherapy. The Slavson Group in New York under the sponsorship of the Jewish Board of Guardians has been most active and prolific in research and publication of reports. This group has attempted to classify the technique and dynamics involved in group psychotherapy.

There are several different schools of psychiatry, and each practitioner of each school varies the application of psychotherapy to meet the needs of each patient. Similarly, in group psychotherapy, psychiatrists adapt their particular technique to the group. And no one method should be considered uniquely correct to the exclusion of any other. Slavson and co-workers, after a number of attempts classified group psychotherapy into two major categories: activity group psychotherapy, and analytic

group psychotherapy. There are several subdivisions of each (which, however, tend to overlap one another) which are adapted for various age groups and clinical problems. The subnames suggest the techniques: Play Group Psychotherapy, Activity Interview Group Psychotherapy, Interview Group Psychotherapy, and Analytic Group Psychotherapy. Analysis and interpretation, which are rooted in Freudian dynamics and concepts,[5] are the dominant features of the latter.

The present discussion is based on experience with group psychotherapy at Resthaven Sanatorium, Los Angeles, a 52-bed institution for female patients between the ages of 16 and 55 who have relatively mild mental ailments and who have sufficient self control to be maintained in an open sanatorium. The stay of a patient at Resthaven averages 42 days; the range is from a few weeks to, in some cases, many months. The patients are admitted by court commitment, or by referral by community agencies, by physicians, or by staff members. The majority of the patients are "clinic" patients; their hospital stay is paid for from public funds, or by some community agency, or by themselves, but they are assigned to various staff members on a clinic or non-pay basis for psychiatric care.

The author started group psychotherapy at Resthaven about a year ago. Eight women, most of them patients of other staff psychiatrists, made up the initial group. The intention was to keep it at this figure, but since it was an "open end" group (new patients being constantly admitted, other patients being discharged) the number varied from six to double that figure. The length of stay in the group varied also with the stay in the hospital and sometimes the patients were not assigned to the group until after they had been in the hospital for some time and were psychologically available for group psychotherapy. Criteria for eligibility to group psychotherapy were that the patients had to be of normal intelligence, in contact with reality, not in extremes of panic or depression, and desirous of participating in this activity. Each patient was given a pre-group interview. Patients with various kinds of disorders participated — neurosis, psychoneurosis, manic-depressive state, and schizophrenia in partial remission with the patient in good contact.

After several months of biweekly group psychotherapy, as the patients were being discharged from the sanatorium some of them expressed a need and desire to continue with group psychotherapy, and the author, after consulting with the staff, continued with some of them on a weekly out-patient convalescent basis. It was suggested that group psychotherapy for out-patients would be of greater benefit if it could include the husbands. The group was enlarged for co-education of patients with their husbands or, in some cases, the mother, and, in one or two cases, the daughter. As the therapist had to keep the number to manageable proportions in order that there might be reasonable participation by those attending, it was necessary to terminate the participation of those who had attended longest, to make room for patients who had recently been discharged and who had the greater need for group psychotherapy. As some of the patients thus discharged still felt they needed group psychotherapy, the author formed another group, to meet weekly at his office, in which some of the patients participated on a private pay basis. Other patients, not included in group psychotherapy, asked to be admitted but had to be refused for lack of room.

About forty patients have participated in these groups for periods of from two weeks to as much as ten months (to date). One-third of the patients did not continue participation as out-patients. Of the remaining two-thirds, about 25 per cent discontinued attendance for various reasons, an additional 25 per cent had to be "graduated," as previously described, to keep the size of the group within therapeutic limits, and the rest, at the time of this report, were still continuing within one or the other of the two out-patient groups. With few exceptions, the patients are married and have been continuing in group psychotherapy once a week with their husbands, one with her daughter.

A stenographic report has been made of most of the group sessions. During the first three months, a volunteer stenographer transcribed shorthand notes. Later an electronic tape recorder was used and transcripts were made by stenographer-patients in the group, who had much interest in listening to their own discussions. Some of the sessions were not recorded, partly because the subject matter was repetitious and partly because the job of transcribing became too burdensome. It takes about six hours to transcribe a session of an hour and a half. On one occasion, a paranoid patient who was engaged in a difficult divorce suit was apprehensive that the recording of her conversation might be used against her in the litigation. However, after an explanation by the psychiatrist and consultation with her attorney, she continued the group psychotherapy sessions. After the divorce was granted and the patient was discharged from the sanatorium, she continued with the group psychotherapy as an out-patient.

The patients reported at first that their husbands were skeptical and hostile to participation in group psychotherapy. Usually, however, after attending

several sessions, the husbands developed a better concept of psychiatry, were enthusiastic in attendance and participation, and became more tolerant and emphatic. Some of them recognized their own need for psychotherapy and one supplemented group psychotherapy with individual analysis.

The author's experience in group psychotherapy began a number of years ago at the Veterans Administration Neuropsychiatric Hospital. The subject was introduced to the group of patients with a series of lectures, as a frame of reference for their orientation in the group and as individuals in the social structure. The dissertation was called "Human Nature and Culture—Two Sides of the Same Coin." The concept is that, assuming reasonably normal births, normal constitutions, and normal intelligence, the individual then is the product of environment. He brings with him all the potentialities for individual development, and his personality is molded by the culture and society about him. A step by step explanation is given of the scientific research supporting this theory. (Pavlov's experiments in conditioned reflex, for instance—producing positive reaction to the sound of a bell; and the perverse negative reaction: a dog is subjected to a terrifying experience on being given meat, until he learns to cringe from the good things in a dog's life.) Additional discussion indicates how purely autonomic and automatic activities are learned, controlled, or changed. This is for the purpose of explaining the extent of activities which are unconscious, automatic, and are subject to conditioning. An exploration of Freudian research and theory clarifies the development of libidinal cathexis, psychosexual cycle, attitude formation, defense mechanisms, and dynamics, and so to the theory of the conscious and unconscious mind. Finally, it is established that the individual is sufficiently plastic that he can relearn appropriate feelings and attitudes and unlearn exaggerated defense mechanisms, as long as he is not organically deteriorated and has a normal intelligence quotient.

While all the dynamics and techniques used in individual analysis are used in group psychoanalysis, the following are noted and will be specifically discussed: Transference, catharsis, interpretation, insight and/or ego building, and finally social interaction, through reality testing and sublimation.

TRANSFERENCE

The ego-involvement of the individual with his parents, siblings, teachers, authority and other members of society is the dominant determinant expressed by his feelings and attitudes in his object relationships and to himself. This ego-involvement is similarly projected toward the therapist as the *father-figure* and to the individuals of the group as the siblings of his family and as society. The patient enters the group emotionally traumatized, with acquired fears, anxieties, and self-rejection. Under the censorship of the super-ego, he has had to repress his feelings and feels guilt-ridden. This has led to reaction formation, exaggerated mechanisms of behavior in an attempt to adapt himself to what he feels to be a threatening and hostile environment. The result is maladjustment, neurosis, and mental illness. Finding in the therapist and members of the group a miniature social setting, the patient displaces upon them these repressed unconscious guilt and anxiety-evoking feelings and attitudes. But this is an attenuated milieu, less threatening and more accepting to the battered ego. This transference in the group is the major dynamic, is therefore diluted both quantitatively and qualitatively and is therefore less threatening to the patient. It is like a desensitizing dose of allergen to one who has allergic disease. The ego-involvement between the patient and the group (including the therapist) is in a metered dosage which he can tolerate. This, however, is also a disadvantage since it reduces the depth of analysis. Associated with the interaction in the group, there is identification and mirror imaging with other patients. This extends reality object relationship which is so defective in these patients. Alternating positive and negative transference is not uncommon, but the constancy shown by the patients in attending the sessions and some very real social attachments between husband-wife teams to others in the group attest their psychotherapeutic value.

CATHARSIS

Freud based his entire analytic therapy after transference upon free association and catharsis, which reduce tensions, conflicts, and symptoms. Resistance to uncovering repressed feelings is due to fear of violating the ego-ideal and therefore regression to immature urges, interests, and attitudes, which are associated with feelings of repressed frustration, hostility, and sexuality which arouse shame and anxiety. It is necessary that the patient be placed in an emotional setting where he will feel free from fear and misgivings, through acceptance and understanding, and allow himself to regress to stages where his emotional development has been arrested (fixation). These are the repressed emotional tensions. The ego-ideal encouraged by the accepting therapist and supported by the other members in a group where societal censorship is suspended, is able to achieve catharsis of repressed emotions. The anxiety felt by patients in relation to "obscene" words, sex feelings, and hostility to parents, hus-

bands, children, and siblings, is considerably reduced when these subjects are discussed in a matter-of-fact, uncensored atmosphere. Each becomes aware that what she felt to be her secret sin and vice is a universal and not unnatural state.

The resistance of patients to accepting the fact of their mental illness is readily overcome when they learn that the others in the group who look and behave not unlike people in general society, are in the sanatorium because of emotional or mental illness, similar to their own, and that the stigma ascribed to this condition by people in general has no validity. The need to keep up the pretense that it is a mortal sin not to love husband, mother, or child disappears with an understanding of how ambivalence and even strong hostility towards these relatives have their genesis in the feelings of insecurity and inferiority which are part of everyone's personality. The analysis of these dynamics greatly reduces the feelings of guilt and anxiety and the patients mutually encourage each other to regression and catharsis.

Some patients do offer more narcissistic defenses in the form of resistance to regression. It may sometimes be necessary to go beyond analyzing defenses and to attack them directly, but this is a risky procedure and should be undertaken with considerable skill and care.

Identification transference and mutual support often serve to catalyze one another as in evangelical revivals. This is a process of universalization and gives a feeling of acceptance.

Group psychotherapy sessions are not always friendly and placid, nor are they intended to be. On several occasions the author has invited the members of the group to analyze and express their feelings toward the therapist and each other, with some amazing results. The meetings usually end on a most friendly note, which is a measure of transference and libido gratification and attests to the value of the group meeting. The subjects usually creating the greatest tensions are feelings of hostility and destructiveness toward children, parents, and husbands in that order, guilt feelings about sex, sex practices, homosexuality, feelings of inferiority and the concept of mental illness.

INTERPRETATION

Interpretation differs from explanation in that the latter is an intellectualization of the manifest content whereas interpretation deals with the latent feeling and motive. Resistance to repressed emotions is often cloaked in rationalization. It is obvious that the patient is using this as a defense against anxiety, and if the condition is severe, it is sometimes not wise to make a direct interpretation which may increase the anxiety. In such circumstances, a similar but disguised and hypothetical situation is introduced for group discussion and group interpretation, with a request to the anxiety-ridden member for her interpretation. The immediate personal situation is then resurrected and the particular member is usually then able to interpret her feelings and dynamics, with resultant relief of anxiety. While this gives understanding and insight, it does not always permit this new insight and reason to carry over to control emotion and behavior in a future situation. But it does improve ego strength and lessen the intensity and frequency of emotional conflicts.

Not all members of a group are equally ready to accept an interpretation at the same time, and it then becomes necessary to concentrate attention on a particular patient. Others show their empathy for this patient by giving comparable illustrations of their own life situations, which tend to reduce the anxiety of the individual, making interpretation more acceptable. This is treatment of a patient in a group through group treatment. It is not attempted to interpret every latent and unconscious motivation manifested by patients to the therapist, as patients may become overly conscious and analytical of everything that is said. Where it is felt that interpretation might stop regression and catharsis, interpretation is withheld.

INSIGHT AND EGO BUILDING

In group psychotherapy, the individual can see his dynamics and defense mechanisms mirrored in others and learn to relate the interpretation to himself and others. For example, a 25-year-old patient with a very traumatic broken home background, where there was a more favored younger sister. She has been married five years. Five months ago, she gave birth to a daughter and depression developed. She is extremely narcissistic, dramatic, and has elements of schizoid behavior. At her first appearance in the group, she declared how extremely happy she and her husband were and how much she loved her husband, mother, and daughter who has had to be boarded out since birth and whom she sees every two weeks. Several days ago, her husband had to be admitted to the Veterans Administration Psychiatric Hospital. Her mother wanted to stay with the patient during this period. They both come to group psychotherapy. The patient explained the crisis in her family and stated she did not want her mother to live with her because they get on each other's nerves. She actually had a feeling of relief when her husband went to the hospital because she and her husband had been rivals; and she refused to be intimidated by her mother, who needed to stay with her as a socially acceptable gesture for

her relatives and friends. She stated she was stepping out of her "Helen Hayes role," as her previous play acting had been called. Everyone in the group except the mother agreed with her decision and several offered their help. Through group transference and catharsis, she was able to reduce her narcissism and her feeling of guilt on the score of her repressed hostility toward her family and was able to express her hostility. She clearly identified her feelings and motives, no longer accused herself of being grossly unworthy of her husband and mother, and noted some of her husband's and her mother's neurotic manifestations. Several days later, although faced with some real problems because of her husband's hospitalization, she took inventory of their finances, set up a budget, and stated she wanted to bring her child home if the therapist approved.

The need for social acceptance which gratifies the ego-ideal is a dominant survival value in neurotic and psychoneurotic persons. This leads to rationalization on the basis of the tensions produced by the immediate situation and is a resolution of a problem without reality, purpose, or goal. This concatenation often compounds the difficulties of the patients. Each can see the real needs of the other in the group and each can take a long term perspective of following through to a goal for the other. To illustrate:

One of the patients in a group, a former school teacher, mother of two children, is married to a husband whose sister is married to the patient's brother. The sister-in-law is beautiful, capable, and well-to-do. The patient had a pathologic libidinal attachment to the brother and is extremely jealous and hostile to her sister-in-law, although professing great friendship. She has had several mental breakdowns necessitating sanatorium care and electroshock treatment. Recently, she started back to school to take courses in psychology and sociology. Initially she had great enthusiasm for the courses, but halfway through the semester she became discouraged, fearing failure and ego trauma. She was graded "C" in the courses. While she denies that she needs or wants anything to make her happy, she continually expresses dissatisfaction with her husband, children, and home. The group has readily interpreted her driving ambition to be first in her class, to be the center of attention in the group, to get ahead of the Joneses in her group.

However, the acceptance by the group that such needs, drives, and ambitions are universal and that the desire to be a leader is not immoral, has helped her to continue with her program, which in itself may be the stepping stone to something worth while. This is ego building.

INTRAGROUP DYNAMICS

Some persons endorse group psychotherapy because of its economic virtues. However, the impression should not be left that group psychotherapy is a makeshift made necessary by difficult and exceptional circumstances. There is a contagion in a group which reduces the individual sense of responsibility and conscience, and which gives the individual in the uncensored group a sense of collective strength. As Freud pointed out, the primitive impulses flow more easily in group than they do in individual relationships—as in the primal horde against the totem authority. Where individuals find it difficult to adjust to a group because of its social fixity, they had no difficulty in adjusting to group psychotherapy, because of its social mobility. Because of a permissive atmosphere, individuals essay expression at regressed levels, and when not censored get support for a new ego-ideal. This is reality testing and they find acceptance for themselves as mirrored in the group and the therapist. This is an attenuated social group but some are re-trying wings that have functioned poorly before and now the exhilarating experience encourages them to use them again in the more formal society outside. Social codes are reevaluated and precept and practice are brought more nearly into focus. Horatio Alger and Elsie Dinsmore receive the debunking they so richly deserve, and the facts of life rather than the fantasy begin to have a more robust and not less glamorous structure. An inventory of the patients' very real assets and opportunities in reverse identification gives them a perspective toward purposeful living and new goal-directed energy. Seeing others with a drive to get well produces an incentive, by example, toward the same end.

HUSBANDS AND WIVES

Group psychotherapy for husbands and wives is not to be construed as pink cellophane ersatz for the original heaven where marriages are made. All the patients are dissatisfied with their spouses, children, parents, life, and themselves. They bring their complaints into the group session. The husband is inconsiderate, lazy, and sloppy. He drops his dirty underwear, shirts, and socks all over the home and never washes out the bath tub on the infrequent occasions when he bathes. He is unfaithful, unattractive, uncouth and never has an affectionate gesture for the wife. He is not financially successful and has none of the esthetic graces that are considered cultural attainments. He has no understanding and love for the wife or her needs. He gets into bed with her only to satisfy his sexual desire and leaves her un-

satisfied; or else she merely submits to get it over with.

The wife is a poor housekeeper, parasite, inconsiderate of the needs of the husband who is out battling a hard world for a living. She is sloppy, unattractive and has lost her sexual glamour. She is also unfaithful or she would be if she had the opportunity. She is mean and petty.

Some husbands were forced into marriage to legitimize unborn children. The respective spouses had some pre-marriage glamour—now they have changed.

Or have they changed? Granted the non-static personality and the gradual changes brought about by organic maturation and senescence, they discover that the real change is in the apperception of the complaining spouse who has shed the rose colored glasses with which he or she first appraised his or her spouse, and that in the emotional view box, there has now been substituted a stigmatic mirror which gives a distorted image of the spouse. He or she sees not what is, but what he or she feels as reflected in one's own feeling of inferiority and dissatisfaction with one's self.

And so the classes discuss: Why do people get married? What is love? What is the reality of the marriage union? On paper, the patients' stories, experiences, attitudes, and feelings sound sordid, not at all like those of a fairy tale princess, for the patients are real and are not different qualitatively, but only quantitatively, from the so-called normal in their feelings, attitudes, and behavior.

Recrimination openly expressed in the group, giving vent to repressed feelings, find universality, and therefore become less threatening and less guilt-ridden. The luck which the patients had fancied as sheltering the domestic lives of other persons at last begins to look more nearly like their own, and so comes better self-acceptance and understanding and acceptance of the spouse. Understanding the dynamics underlying the recriminatory behavior takes away much of the sting, and husbands and wives develop empathy for each other. They need no longer so strongly "repress the desire to sin and the guilt thereof."

THE ROLE OF THE THERAPIST

The role of the therapist in group psychoanalysis is the same as in individual psychoanalysis. It is based on transference, catharsis, interpretation, the development of insight and ego building, and reorientation to the social group. The therapist should have complete anamnesis for each patient, and must understand the psychodynamics of each patient, particularly the nuclear problem. He must have a plan of treatment in relation to a particular patient, as to depth of analysis and treatment goals. The therapist must recognize that although patients may have a variety of conflicts, all have the same basic tensions, primarily associated with parents and secondarily with siblings, real or social. He must be prepared to deal with libidinal sexual strivings whether for the same sex or opposite, and positive or hostile. When catharsis is displaced upon the therapist, libido is detached from earlier ego involvements, and ego defenses are diminished. As emotional conflicts are reduced, these patients find that in turn their attitudes toward parents and others become less tense. Slavson called this "transference in reverse." The therapeutic process occurs when, after expressions of hostility, release of tension and insight take place, resulting in "psychic homeostatis," integration and emotional maturity.

While the therapist should not be authoritarian, he must not be passive. His role is to orient, stimulate, and particularly to understand. Nothing so frustrates a patient as the feeling that the psychiatrist does not understand. In this permissive climate the patient can discuss every subject from hair-dos to religion, but the therapist is required to focus the discussion within reasonable bounds for relevancy, and occasionally may have to divert it when a subject becomes too anxiety-provoking. Sometimes patients need supplementary individual interviews to discuss some problem which is too anxiety-ridden for them to discuss in the group.

Therapeutic goals differ from patient to patient. As in individual analysis, there is today some professional controversy as to whether it is always best to proceed to deep analysis of the pre-oedipal basis for neurosis, or to give symptomatic relief by helping to resolve the present emotional conflicts by dimininishing the ego-ideal and developing a more tolerant attitude by the patient toward himself. Termination of treatment calls for both great skill and professional acumen. It should be planned with a final individual interview as a graduation exercise, rather than have it terminate in a desultory manner which might seem to the patient to be the earmarks of failure in another course.

570 North Rossmore Avenue.

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